STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Island Ohana Care	**CHAPTER 100.1**
Address: **3846 Noeau Street, Honolulu, Hawaii 96816**	**Inspection Date: April 14, 2020 Initial**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Menus are not followed. On the day of the inspection, Lanakila Meals on Wheels frozen meals from another individual was brought to the ARCH by a care giver. The residents were served different Lanakila Meals on Wheels entrees for lunch.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - New cycle menus was created and residences preferences was also considered and was put in the menus. - Notified all care givers to do not bring in frozen meals or meals from the Lanakila meals on wheels. -	4/15/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Menus are not followed. On the day of the inspection, Lanakila Meals on Wheels frozen meals from another individual was brought to the ARCH by a care giver. The residents were served different Lanakila Meals on Wheels entrees for lunch.	PART 2 **FUTURE PLAN** USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? - - - The (PCG) Ninan Barnes and assistant (SCG) Imie Rose Zaluaga are responsible in ensuring that the menus are followed and are written one week in advance, revised periodically, dated correctly. - New cycle meal plan was created and residence preference was also considered and was put in the menus. Cycle menu must be strictly followed by all care givers. - Assistant SCG and PCG will monitor the daily menu and actual meals being serve daily with the other SCGs. - I notified all caregivers during our meeting to do not bring any frozen or ready made meals from stores or from any meals on wheels program. - PCG and the assistant SCG will have a daily check up on what is being stored in the Care home's refrigerator and freezers. - PCG should implement a strict regulation about what the care givers can bring in. Care giver's are not allowed to bring in any outside food to share to the residents.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (e) Substitutes offered to residents who refuse food served shall be of similar nutritive value and documented. **FINDINGS** No substitution list recording substitutions made to the posted menu.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - - We made a list of substitute meals and was written on the menus. - All care givers were informed to record the meals that was serve that day on the alternate meal log.	9/15/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (e) Substitutes offered to residents who refuse food served shall be of similar nutritive value and documented. **FINDINGS** No substitution list recording substitutions made to the posted menu.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - We corrected and made a list of substitute/ alternate meals that was added in the menu list. - The substitution menu will only be used if the resident refused to eat the food that is being serve from the regular menu list. - All care givers were informed and trained to record the alternate meals when it is being served. Alternate menu log should be accessible to all care givers.	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS** Lanakila Meals on Wheels frozen meals were transported to the ARCH by a care giver. The care giver stated that the recipient of the frozen meals did not like the meals.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Notified and prevented all care givers to bring in frozen foods or from Lanakila meals on wheels, or from other home or clients.	9/15/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS** Lanakila Meals on Wheels frozen meals were transported to the ARCH by a care giver. The care giver stated that the recipient of the frozen meals did not like the meals.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? - All the existing or new care givers must be trained to cook and or prepare the scheduled meals on the planned menu. - PCG is preventing all care givers in bringing in any outside meals frozen or hot. All care givers was informed in the monthly meeting. - I notified all caregivers during our meeting to do not bring any frozen ready made meals from stores or from any meals on wheels program. - Assistant SCG and PCG will monitor the daily menu and actual meals being serve daily with the other SCGs. - Aside from announcing to all care givers that they are NOT allowed to bring any frozen or meals on wheels meals, we also have a sign visible to everyone in the kitchen to remind them what is not allowed to prevent any future deficiencies.	

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☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Toxic chemicals and cleaning agents were unsecured in the laundry area. Even when brought to the attention of the SCG, the door to the laundry area remained open and unlocked during the inspection.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY - During the inspection, the inspector made us aware of the other chemicals outside. The SCG then made sure all the chemical was put inside the Chemical cabinet and locked it. The SCG missed to inform the inspector that the cabinet was locked right after it was brought up by the inspector. The SCG missed to inform or show the locked chemical cabinet to the inspector before she left. Hence I don't think it is necessary to locked the laundry room since all toxic chemicals was inside the locked cabinet found in the laundry room. - Right after the inspector left, all care givers was informed and trained the proper way to store away all toxic chemicals and that it has to be put way inside the chemical cabinet in every use of each cleaning or toxic chemical supplies. All care givers we're informed and trained where to store away the chemical cabinet key and that it has to be place back in the assigned place for easy access and use.	

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☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Toxic chemicals and cleaning agents were unsecured in the laundry area. Even when brought to the attention of the SCG, the door to the laundry area remained open and unlocked during the inspection.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? - To prevent this deficiency in the future, the PCG and the Home manager SCG will ensure to check the chemical cabinet to make sure it is securely locked at all time. To check all the rooms for all other toxic chemicals laying around. It is the PCG's responsibility to double check daily. Aside from notifying all care givers, a signage reminder is posted by the chemical cabinet and the kitchen for everybody to see. - All care giver's are notified and are reminded to check all toxic chemical before and after shift. Especially when they did the cleaning that day. - Hence, we have a lockable chemical cabinet, the laundry room need not to be locked. We'll just have to make sure that the chemical cabinet is locked at all times, and that the key should be found in an accessible location for everyone to use when it is needed. -	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** On 3/10/20, the substitute care giver (SCG) reported she received a telephone order: "fludrocortisone 0.1 mg Take 2 tabs by mouth daily" decreased to "1 tab daily." The label was changed from 2 tabs to 1 tab by the substitute care giver.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Unable to correct the label/ the deficiency. Resident was discharged on 6/18/2020	11/27/2020

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☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** On 3/10/20, the substitute care giver (SCG) reported she received a telephone order: "fludrocortisone 0.1 mg Take 2 tabs by mouth daily" decreased to "1 tab daily." The label was changed from 2 tabs to 1 tab by the substitute care giver.	PART 2 **FUTURE PLAN** USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? - In the future, I will bring the actual medication to the doctor's office to correct the label & ask for doctor's initial ~~and date~~ N/A and must be dated correctly. - We will not make changes to the medication label.	11/11/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 - No physician order for the following noted on the medication record: ◦ "Fludrocortisone 0.1 mg one tablet daily" recorded on the March 2020 and April 2020 medication record. ◦ "Carbidopa/levodopa 25-100 mg Take 2.5 tabs by mouth 3 times a day" recorded on the April 2020 medication record.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY - We corrected the deficiency by calling the doctor's office to clarify the order and made them aware of the differences of the order and that it needs changes. We then requested and acquired the new written order of the prescription and signed by the physician . - A new written prescription for the "Fludrocortisone and carbidopa / levodopa was obtained via faxed to the home.	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication. **FINDINGS** Resident #1- On 3/24/20, the SCG stated she received a telephone order to decrease "carbidopa/levodopa 25-100 mg from 3 tabs to 2.5 tabs 3 times a day." The telephone order was not recorded on the physician order sheet. The label read "3 tabs 3 times a day."	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - SCG was deligated to follow-up on the physician's phone order to make a correction and to clarify the order from the physician's clinic. - SCG then was ordered to record the phone order in the physician's order sheet. And corrected the MAR - All SCG was notified and make aware to the correct changes of medication dosage and time or frequency of administration.	4/24/2020

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☒	§11-100.1-15 Medications. (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication. **FINDINGS** Resident #1 - On 3/10/20, the SCG stated that she received a telephone order to decrease "fludrocortisone 0.1 mg 2 tabs daily" to "one tab daily." The telephone order was not recorded on the physician order sheet. The label was changed by the SCG from "2" tabs to "1" tab.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - PCG called the doctor's office to clarify the change of medication dosage. - Doctor faxed the new order to PCG. - Resident was discharged 6/18/2020	1/17/2021

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Resident #1 - celecoxib" discontinued on 3/4/20; however, the discontinued medication was found with the current medication. "Discontinued" was written on the label of the bubble pack.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Celecoxib was immediately removed from other current medication box. It was placed separately in a ziplock and labeled name of resident and " discontinued medication".	4/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. FINDINGS Resident #1 - celecoxib" discontinued on 3/4/20; however, the discontinued medication was found with the current medication. "Discontinued" was written on the label of the bubble pack.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? - All care givers will be notified via text and in a meeting about any changes on resident's medication and instructions. - A written reminder notice will also be posted on the residents folder next to MAR and medication box. And have all caregivers signed the notice. - In the future, all discontinued medication will be removed immediately from the medication box. Put it separately in another Ziploc bag and labeled "discontinued medications". Discontinued medication can also be returned to the pharmacy for their proper disposal especially if the medication is narcotic. The PCG is responsible for the disposal of the discontinued medication and will arrange the transport and turn over to the right pharmacies. Primarily, it is the PCG's responsibility to removed the discontinued medication away from the rest of the resident's current medication. It is also the PGC's responsibility to train the all SCG to properly remove the medication.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1 - The April 2020 medication record was not initialed by the care giver on 4/12/20, 4/13/20 and 4/14/20 (a.m.)	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - The in charge/ on duty SCG that day on 4/12/20, 4/13/20 and 4/14/20 a.m. who administered the medication updated the MAR and initialed. - Reminded all the care givers to sign and initial the MAR as soon as the medication was administered.	4/14/2020

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☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1- On 3/24/20, the SCG stated she received a telephone order to decrease "carbidopa/levodopa 25-100 mg from 3 tabs to 2.5 tabs 3 times a day." The March 2020 medication record noted that the order for the "3 tabs" for the remainder of the month was crossed out; however, there was no documentation that the "2.5 tabs" was made available to the resident. - The April 2020 medication record noted the "2.5 tabs" order. - -	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Called the physician office and requested for the new and corrected medication order of 2.5 tabs as indicated. A new medication order was attached to the remaining medication bottle. Notified all care givers to follow the new medication order attached to the medication bottle and compare it to the new MAR. All care givers were remined NOT TO CROSS OUT any words on the medication label.	
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☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1- On 3/24/20, the SCG stated she received a telephone order to decrease "carbidopa/levodopa 25-100 mg from 3 tabs to 2.5 tabs 3 times a day." The March 2020 medication record noted that the order for the "3 tabs" for the remainder of the month was crossed out; however, there was no documentation that the "2.5 tabs" was made available to the resident. The April 2020 medication record noted the "2.5 tabs" order.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - All SCGs are notified not to cross out any words on the medication label. - We'll ensure that all medications, supplements and formulas should immediately be recorded when taken by residents on the medication record (MAR), with date, time, name of drugs and dosage initialed by the administering care givers.	9/14/2020

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☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1- On 3/24/20, the SCG stated she received a telephone order to decrease "carbidopa/levodopa 25-100 mg from 3 tabs to 2.5 tabs 3 times a day." The March 2020 medication record noted that the order for the "3 tabs" for the remainder of the month was crossed out; however, there was no documentation that the "2.5 tabs" was made available to the resident. The April 2020 medication record noted the "2.5 tabs" order.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? We will ensure in the future that any changes on the medication or physician order will be promptly and accurately documented on the medication record by updating the MAR, right away, noted and documented on the physician order, progress notes and give all care givers notice of the change. - Make sure to update the new physicians instruction, like the name of medication, right time, right dose, right resident and right route. - The PCG is responsible in reviewing the documentation made by the other care givers. The PCG will ensure that the other care givers accurately record the telephone order and documented the order correctly on the MAR. - We will ensure that the physician order will be followed accurately as soon as possible. The telephone orders will be follow up by calling the physician office to request for an updated medication order. The order should be documented across the care home forms/ sheet like the physician order sheet, progress notes and MAR. New Medication change notice will be posted in the resident's folder next to the MAR for other care giver's to follow.	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Height and weight measurements taken; **FINDINGS** No admission height and weight for four (4) residents.	PART 1 **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - We immediately took the resident's height and weight and record it on admission height and weight record.	9/14/2020

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☒	§11-100.1-17 Records and reports. (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Height and weight measurements taken; **FINDINGS** No admission height and weight for four (4) residents.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - In the future, I will use the ARCH admission checklist to keep track of what needs to be done upon admission. - I will remind all care givers to record the height & weight of each residents upon admission. - I will double check the admission checklist to make sure all documents are complete and filed.	1/27/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A current inventory of money and valuables. **FINDINGS** Resident #1 - Inventory did not include the resident's walker.	PART 1 **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - We immediately record and completed the inventory list and include the walker. - We'll make sure to thoroughly check and list all residents belongings and record it to the inventory form of each residents.	9/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A current inventory of money and valuables. **FINDINGS** Resident #1 - Inventory did not include the resident's walker.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - We'll make sure to thoroughly check and list all resident's belongings and record it to the inventory form of each residents upon admission. - PCG or the home manager will review to double check the inventory.	4/19/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 - On 3/10/20, the physician was informed of three (3) falls (no dates specified); however, no progress notes of the falls.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - We made an investigation on who was the on duty care givers on the previous falls. The on duty caregiver who was on duty and witnessed the falls, wrote a documentation on the progress notes about the falls. It was recorded, on 4/14/20 stating the dates of the falls on 2/ 28/20 @ 2pm, 3/05/20 @7:30pm, and on 3/09/20 @ 9pm.	4/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 - On 3/10/20, the physician was informed of three (3) falls (no dates specified); however, no progress notes of the falls.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Provide an in-service training to all caregivers on recording incident reports. - When an incident happens, such as falls, PCG will inform physician and asked for advise. Such advise will be recorded on the resident's progress notes. - PCG will also inform resident's family/ legal representatives of the incident.	4/15/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 - On 3/10/20, the physician was informed of three (3) falls (no dates specified); however, no progress notes of the falls.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - In the future any incident needs to be recorded on the progress notes. - I will place a post-it note on the incident report as a reminder to document incident on the progress notes	1/27/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1 - On 3/10/20, the physician was informed of three (3) falls (no dates specified); however, no incident reports were initiated.	PART 1 **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - We made an investigation on who was the on duty care givers on the previous falls. The on duty caregiver who was on duty and witnessed the falls, wrote a documentation on the **incident report** regarding the three falls. It was recorded on 4/14/20 stating the dates of the falls on 2/ 28/20 @ 2pm, - 3/05/20 @7:30pm, and on 3/09/20 @ 9pm	9/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1 - On 3/10/20, the physician was informed of three (3) falls (no dates specified); however, no incident reports were initiated.	PART 2 **FUTURE PLAN** USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? -PCG did conduct an in-service training to all care givers on where, when and how to fill-up incident reports. -All incident must be recorded on the progress notes. -filled-up incident reports will be reviewed by the PCG and will be made available in a separate folder/cover for incident reports.	1/27/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident #1 - White-out used on the February 2020, March 2020 and April 2020 medication records.	PART 1 **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Made all SCGs aware not to use a white-out in any documentation or reporting.	9/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident #1 - White-out used on the February 2020, March 2020 and April 2020 medication records.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** -A notice is in placed in each of the resident's folder that white-outs are not allowed. - If correction is needed, strike-out the data, write the correct data on top or to its side, and initial of the staff must be visible - PCG will check charts weekly to ensure correct entry	4/15/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** The permanent general register did not include admission dates for two (2) residents.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Two (2) new resident's names was added immediately in the general register with the dates of admissions.	9/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** The permanent general register did not include admission dates for two (2) residents.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - We'll ensure that all new resident's name should be immediately added to the general register to record all admission and discharge of each of the residents.	4/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(E) Residents' rights and responsibilities: Each resident shall: Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs; **FINDINGS** Resident #1 - No consent for the use of the surveillance camera directed at the resident's bed. The hand-held monitor was on the kitchen counter. No policy and procedure for the use of surveillance cameras.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - We immediately made a surveillance/ video monitor form and photography consent form signed by resident. A copy was sent via email to the daughter. - The monitor was turned off after the inspector left. - Surveillance monitor policy was added in to the General Policy and Admission Agreement .	9/14/2020

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(E) Residents' rights and responsibilities: Each resident shall: Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs; **FINDINGS** Resident #1 - No consent for the use of the surveillance camera directed at the resident's bed. The hand-held monitor was on the kitchen counter. No policy and procedure for the use of surveillance cameras.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - We added a video monitor and photo consent form to be signed by the resident, family or guardian upon admission of each of the residents. - Monitor should not be displayed in an open space where everyone can see. - Video monitor and photo policy and procedure were added into the ARCH's General Policy and Admission Agreement.	4/14/2010

Licensee's/Administrator's Signature: _____

Print Name: NINAN BARNES

Date: 06/01/2020

Licensee's/Administrator's Signature: _____

Print Name: NINAN BARNES

Date: 07/21/2020

Licensee's/Administrator's Signature: _____

Print Name: NINAN BARNES

Date: 10/02/2020

Licensee's/Administrator's Signature: _____

Print Name: Ninan Barnes

Date: 1/27/2021